MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev., Jul 99)

SEAT LIFT MECHANISM

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH MEDICAID I.D. NUMBER:	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER MEDICAID PROVIDER NUMBER:

DIAGNOSIS:	HEIGHT: WEIGHT:
PROGNOSIS:	EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99 = LIFETIME)

1. Current residence: (circle the appropriate) Home, Nursing Home, Hospital Rehab Unit, Institution, Group Home, Other _____

2. Does patient have severe arthritis of the hip or knee? Y / N

3. Does patient have severe neuromuscular disease? Y / N

4. Is the patient completely incapable of standing up from a regular armchair or **any** chair in his/her home? Y / N

5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position been tried and failed? Y / N

6. Once standing, does the patient have the ability to ambulate? Y / N

7. Narrative description of **ALL** items, accessories and options: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document.)

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services